Attachment B-- Affected Population:

The affected population is the uninsured parents of Title XXI SCHIP children with earned incomes at or below 133% FPL, dually eligible under the 1931 expansion and 1115 waiver (SCHIP), (AFDC Medicaid expansion).

Attachment E - Private Health Insurance Coverage Options

NJ FamilyCare/Premium Support Program

The NJ FamilyCare/Premium Support Program (PSP) was previously approved by CMS as part of the 1115 Waiver demonstration that authorized the NJ FamlyCare Program, (9/00). The PSP was implemented on 7/1/01 and is currently enrolling NJ FamilyCare eligibles into their employer-sponsored health plans.

PSP Description

The Premium Support Program is designed to cover individuals eligible for NJ FamilyCare who have access to employer-sponsored health plans. Assistance will be provided in the form of a direct subsidy payment to the beneficiary for a portion of the payroll deduction required for participation in the employer-sponsored health plan. Beneficiaries will be reimbursed on a regular schedule, to coincide with their employer's payroll deduction, so as to minimize any adverse financial impact on the beneficiary.

All applicants to the Premium Support Program shall first be found eligible for the NJ FamilyCare program. Applicants to the Premium Support Program shall provide information concerning employment and employer-sponsored health insurance benefits. If an otherwise eligible applicant has access to employer-sponsored health benefits, the applicant must enroll in the Premium Support Program.

An application to participate in the Premium Support Program shall be supported by the indication by the applicant's employer that the employer contributes, at a minimum, 50 percent of the annual cost of the insurance premium for the employee (and family, as applicable). If the employer does not contribute 50 percent of the premium cost, the PSP application shall be denied and the applicant shall continue to participate in a State-contracted managed care program through the NJ FamilyCare program.

Cost-effectiveness shall be determined by comparing the cost of the beneficiary/employee and all eligible family members' participation in the NJ FamilyCare program against the total cost to the State of reimbursing the beneficiary/employee for the employee share of the cost of family coverage less a monthly premium contribution amount for the family purchasing the employer plan.
The amounts used for the calculations shall be derived from actuarial tables used by the NJ FamilyCare program and actual costs reported by the employee/employer during the processing of the Premium Support Program (PSP) application.

All Premium Support Program (PSP) payments will be made directly to the beneficiaries, for a portion of the amount payable to the employer by the beneficiary for the employer-sponsored health plan.

The periodic payments to the beneficiary will coincide with the schedule of payroll deductions as established by the employer.

The amount of the periodic payments to the employee shall be the amount of the employee's contribution to the employer's plan, less the monthly NJFC/PSP premium amounts for which the employee is responsible, in accordance with N.J.A.C. 10:78-9.13.

If, during the course of a regular span year (January 1 to December 31), the beneficiary and/or any other eligible family members incur cost sharing expenditures (copayments, co-insurance and deductibles) that are not directly reimbursable by the Premium Support Program (PSP), and that exceed five percent of the individual's or family 's gross annual income, they may submit proof of such expenditures to the PSP for review and possible reimbursement, in accordance with the provisions of this section. If the beneficiary chooses an employer-sponsored plan which costs more than the basic plan approved by the Premium Support Program for that employee and/or any other eligible family members, the difference between the approved premium and the actual premium is the responsibility of the employee.

Participants in the NJ FamilyCare/Premium Support Program shall be eligible for all covered services based on their NJ FamilyCare category of eligibility (Plan A, B, C or D). Premium Support Program (PSP) participants shall utilize their employer-sponsored plan as primary coverage.

Any eligible services not covered by the employer plan, but covered under the enrollees' NJ FamilyCare category of eligibility, will be available to PSP participants as a "wraparound: service. Any such wraparound service (for example, optical appliances or hearing aids) shall be provided by a New Jersey Medicaid/NJ FamilyCare participating approved provider. The failure of a beneficiary to use a New Jersey Medicaid/FamilyCare provider for "wraparound services" will result in a denial of payment by the NJ FamilyCare Program. The services received would then be the full responsibility and liability of the beneficiary, (see attached listing of "wraparound" services for each plan).

Attachment D – Measuring Progress Toward Reducing the Rate of Uninsurance

New Jersey will measure the progress of reducing the rate of uninsurance in two ways. First will be by evaluating Current Population Survey (CPS) data longitudinally over a period extending back prior to the advent of the NJ FamilyCare program.

Additionally, because the New Jersey CPS sample is relatively small, we will make use of a new 3,500-household sample representative survey, conducted by the Rutgers University, Center on State Health Policy. While that survey has been conducted only once, a second wave is anticipated before the end of the life of this waiver.

Attachment F – Public Notification Process

As indicated on the documents included as Attachment F, several forms of notification have been issued. They are as follows:

- Notification to State Legislators
- Legal Notice
- Notification to Advocates
- Notification to Key Providers

Attachment H - Conditions of HIFA Waiver:

The State proposes and requests CMS approval to:

- Standardize the benefit package September 1, 2002 for all adult/parents as described at 42 CFR Part 438, Subpart C, including Section 1902 (r) (2) and Section 1931 expansion population.

- This would include all current eligibles participating in the NJ FamilyCare program on June 15, 2002 as well as, all those applicants on hand on June 15, 2002 that are subsequently determined eligible for NJFamilyCare coverage.

- Effective September 1, 2002 all such affected NJ FamilyCare adult/parent population as described herein would be eligible for a specified package of services (commonly referred to as Plan "D", NJ FamilyCare coverage) regardless of category of eligibility or below 200% FPL.

- The effect of this change would be to reallocate such savings as derived from modifying adult/parent coverage from Plan "A" (Medicaid) coverage to Plan "D" NJ FamilyCare. This would also permit additional adult/parent coverage for those whose application was submitted but not finalized before June 15, 2002.

- The State will continue to maintain Medicaid eligibility standards for children as of June 1997 as prescribed as well all current provisions of eligibility for children as defined in the present 1115 waiver amendment for NJ FamilyCare.

- Children's service levels will remain unchanged by this HIFA Waiver. Children will continue to receive the appropriate service package under NJ FamilyCare depending on their category of eligibility determined by their FPL.

Attachment C

NJ FamilyCare

Plan D Service Package

NOTE: Any family member or adult enrolled in this plan is only eligible for service after enrollment in managed care. Premiums and co-payments are required for families and children with income greater than 150% of the Federal poverty level.

Services available through the Health Maintenance Organization (HMO)

- Primary and Specialty Care, $5 co-pay, except for preventive services
- Well child care, including immunization, and lead screening and treatments
- Emergency Room Services, with $35 co-pay for non-emergency treatment
- Family Planning Services and Supplies, including: Medical history and physical exams, diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.
- Home Health Care Services, limited to skilled nursing care for a home-bound beneficiary which is provided or supervised by a registered nurse when the purpose of the treatment is skilled care necessary for the treatment of the beneficiary's medical condition.
- Hospice Services
- Inpatient Hospital Services, including acute care, rehabilitation and special hospitals.
- Outpatient Hospital Services, including outpatient surgery, $5 co-pay, except for preventive services.
- Laboratory Services, $5 co-pay
- Radiology Services – Diagnostic and Therapeutic, $5 co-pay
- Optometrist Services: Including one routine eye examination per year, $5 co-pay
- Optical Appliances: Limited to one par of glasses (or contact lenses) per 24 month period, or as medically necessary
- Organ Transplants
- Prescription Drugs, excluding over-the-counter drugs, $5 co-pay for brand name drugs and $1 co-pay for generic drugs.
- Dental Services, limited to preventive dental services only for children under the age of 12 years; including oral exams, oral prophylaxis, and topical application of fluorides.
- Podiatrist Services, excluding routine hygienic care of feet in the absence of a pathological condition, $5 co-pay.
- Prosthetic Appliances, limit4d to initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease, injury, or congenital defect.
- Private Duty Nursing, when authorized by the HMO

- Transportation Services, limited to ambulance services for medical emergency only
- Maternity and related newborn care
- Diabetic Supplies and Equipment

Services available fee-for-service (FFS)

- Abortion Services
- Skilled Nursing Facility Services
- Outpatient Rehabilitation – Physical Therapy, Occupational Therapy and Speech Pathology: Limited to: (1) non-chronic conditions and acute illnesses and injuries; and (2) 60 consecutive day period per incident o illness or injury beginning with the first day of treatment per contract year. Speech therapy rendered for treatment of delays in speech development, unless resulting from disease, injury or congenital defects, is not covered.
- Inpatient Hospital Services for Mental Health, including psychiatric hospitals, limited to 35 days per year.
- Outpatient Benefits for Short Term, Outpatient Evaluative and Crisis Intervention, or Home Health Mental Health Services, limited to 20 visits per year, $25 co-pay:

    1. When authorized by DMAHS, one (1) mental health inpatient day may be exchanged for up to four (4) home health visits or four (4) outpatient services, including partial care. Limited to an exchange of up t9o a maximum o 10 inpatient days for a maximum of 40 additional outpatient visits.

    2. When authorized by DMAHS, one (1) mental health inpatient day may be exchanged for two (2) days of treatment in partial hospitalization up to the maximum number of covered inpatient days.

- Inpatient and Outpatient Substance Abuse: Limited to detoxification, $25 co-pay for outpatient visits.

Note: Co-pays are not required for General Assistance/NJ FamilyCare or for adults when income is above 50% of the Federal Poverty Line, up to 150% of the Federal Poverty Line.